Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004904	A. BUILDING _____ B. WING _____	03/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HOUSE	601 BUSSARD RD WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Licensure Survey. Survey date: March 9, 2011 Facility number: 004904 Provider number: 004904 AIM number: N/A Survey team: Amy Wininger, RN, TC Melinda Lewis, RN Sharon Whiteman, RN Census bed type: Residential: 27 Total: 27 Census payor type: Other: 27 Total: 27 Sample: 9 Emerald House was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality review 3/10/11 by Suzanne Williams, RN	R 000		